Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya

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December 2004

This study was funded by the U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) under the terms of Cooperative Agreement Number HRN-A-00-98-00012-00 and Population Council In-house Project 5804 13061. The opinions expressed herein are those of the authors and do not necessarily reflect the view of USAID.

ACKNOWLEDGEMENTS

Many organizations and individuals supported this study, particularly the Ministry of Health, Division of Reproductive Health, and the Maendeleo ya Wanawake organization. Special thanks go to the Provincial Medical Officer, Nyanza Province (Dr. Misore); to the FGM coordinator at the Division of Reproductive Health (Mrs. Anne Njeru); and the Provincial Coordinator for Maendeleo ya Wanawake in Kisii (Rose Mwebi) for their support and assistance during data collection.

Humphries Evelia, the Field Coordinator, deserves special thanks, as do all of those who participated in the data collection, data entry and analysis – their enthusiasm and dedication were an inspiration.

Our deepest appreciation goes to the community members, key opinion leaders, managers of health facilities and health providers. Their willingness to participate and share their views and experiences has made it possible to get a better understanding of the reality of female genital cutting in the community. Their experiences form the core of this report and have greatly helped in the formulation of recommendations for feasible and effective interventions to eliminate the practice, not only within Nyanza Province but nationwide.

Lastly, our gratitude is extended to PATH and the National Focal Point for providing important contributions in the design and implementation of the study, and to USAID's Special Initiative for FGC for supporting this study financially.

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LIST OF ACRONYMS

ARP	Alternative Rites of Passage
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior change communication
CHW	Community Health worker
FC	Female Circumcision
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GOK	Government of Kenya
GTZ	German Technical Cooperation for Development
HIV	Human Immunodeficiency Virus
KDHS	Kenya Demographic and Health Survey
MOH	Ministry of Health
MYWO	Maendeleo Ya Wanawake Organization
NGO	Non Governmental Organization
NFP	National Focal Point
PATH	Program for Appropriate Technology in Health
SDA-RHS	Seventh Day Adventist – Rural Health Services
STIs	Sexually Transmitted Infections
UNICEF	United Nations Children's Emergency Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

This study sought to understand the role that health providers play in the medicalization of female genital cutting (FGC) among the Abagusii community, whose members live primarily in the Kisii, Gucha, and Nyamira districts of Nyanza Province in western Kenya, and among whom the practice continues to be almost universal. In recent years, trained health providers have been replacing traditional practitioners in undertaking FGC. This not only perpetuates the practice, but also violates medical ethics, disregards Ministry of Health policy, and contravenes the Kenyan Children's Act of 2001.

Interviews with service providers and their clients revealed an overwhelming belief that FGC fulfils a traditional cultural obligation among the Abagusii, and that it limits a woman's sexual desire and confers respect on girls. Interviewees felt that it would be difficult for a girl to get married if she had not been cut; thus FGC also enables the girl's family to negotiate a better bride price. Girls are now being circumcised at earlier ages, in the belief that younger girls are better able to survive the experience and are easier to convince. The majority of respondents reported that less tissue is cut nowadays and that the procedure is less painful, with local anaesthesia and infection prevention commonly used, and the procedure is often performed within health facilities. Pricking or nicking of the clitoris is a new procedure, carried out mostly by health professionals, and is seen as a symbolic or "psychological" cut.

With medicalization of the procedure, FGC has become a business involving several different cadres of health staff, although most circumcisions are undertaken by nurses or midwives. To these health staff, FGC has become a popular means of economic gain. Some health providers take leave during the August and December school holidays to open temporary "clinics" for FGC, apparently seeing as many as 50 girls per day.

The trend towards medicalization, however, is condemned by traditionalists in the community because it is seen as a violation of the cultural value of the ritual and meaning associated with the practice. Understandably, traditional circumcisers were also opposed to medicalization, because they fear losing prestige. Some saw medicalization as an impediment to the abandonment of FGC as it has created confusion in the community about what is and is not acceptable. Some service providers and community leaders indicated an interest in taking a role in fighting medicalization of FGC and in promoting its total abandonment.

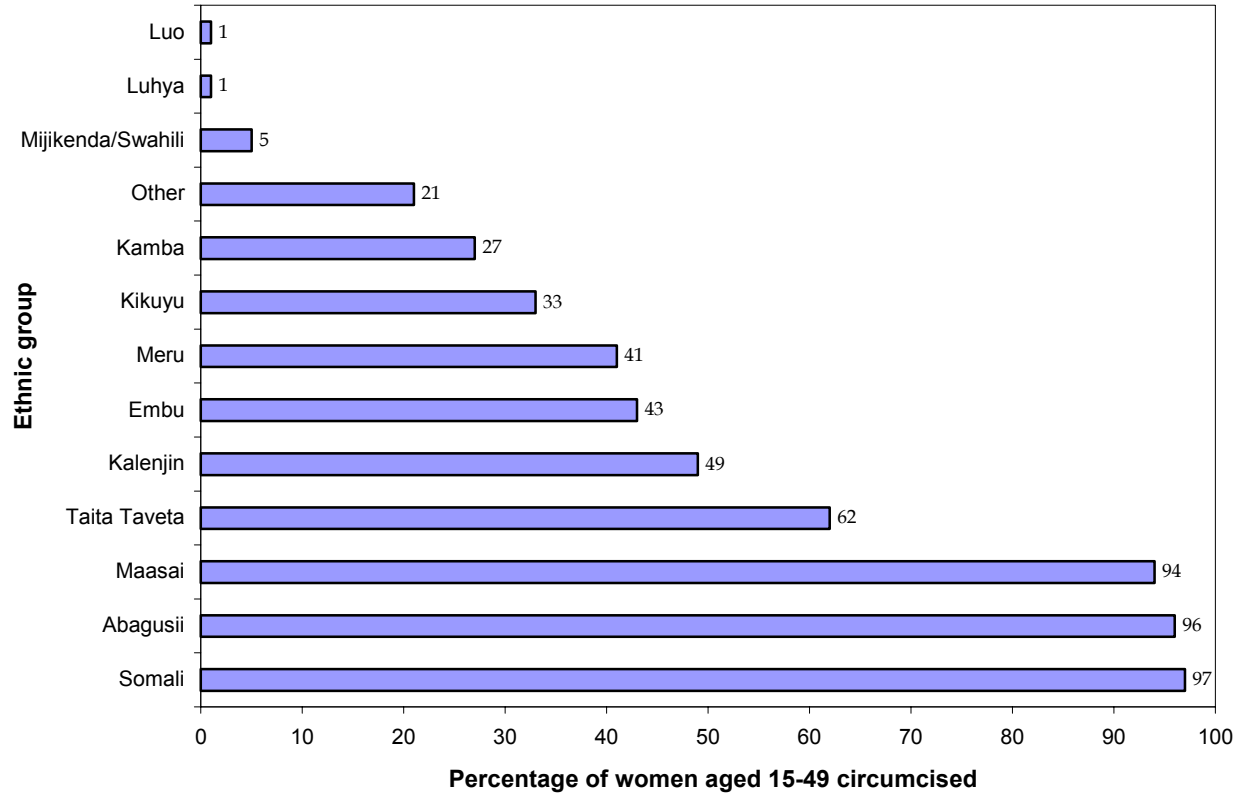
Clearly new approaches are needed within this community to present FGC as violating human rights and national laws, as well as threatening girls' and women's health. The active participation of health staff in advocating against the practice is essential to reduce their perceived support for its continuation, and the Ministry of Health needs to strengthen supervision in these districts. Public education on existing policies and laws is needed to dissuade communities from continuation, and punitive measures should be taken against those health staff caught practicing FGC. Community-wide approaches are needed that present FGC not just as a health issue, but as a practice that violates women's basic rights and promotes female subjugation by suppressing women's sexuality. Such a comprehensive approach should include all stakeholders to change values and attitudes towards FGC. The involvement of men is particularly important, as it is their overall dominance in society that has led to women supporting FGC as a means of gaining social identity and access to resources.

Background

FGC in Kenya

Female genital cutting (FGC)[1], also known as female genital mutilation (FGM) or female circumcision, is practiced in over half of the districts in Kenya, with 34 percent of all women aged 15-49 years reporting being circumcised according to the preliminary results from the 2003 Kenya Demographic and Health Survey (KDHS 2003). This represents a slight decline from the 38 percent reported in the 1998 KDHS. As can be seen in Figure 1, FGC is nearly universal among certain ethnic groups such as the Somali, Kisii, and Maasai, and is highly prevalent among the Taita Taveta, Kalenjin, Embu and Meru groups, and is practiced to a lesser extent among the Kikuyu and Kamba. There are also some ethnic groups, notably the Luo, Luhya and Mijikenda, who do not practice FGC. Clitoridectomy (type 1) and excision (type 2) are the predominant types of cutting practiced, although the Somali, Borana, Rendille, and Samburu practice the more severe (type 3) form of infibulation, which is virtually universal in those cultures and is practiced on girls at pre-puberty and younger ages.

Figure 1. Prevalence of FGC among women aged 15-49 years in Kenya by ethnic group



[1] For the purpose of this report, the term female genital cutting has been adopted, and the WHO classification is used: *Clitoridectomy* involves the partial or entire removal of the clitoris; *Excision* refers to the removal of the clitoris and the labia minora; *Infibulation* is the removal of the clitoris, the labia minora and/or labia majora; raw surfaces are either stitched together or sealed, with a small opening preserved for the flow of menstrual blood and urine. WHO also recognizes an 'unclassified category' of FGC that includes the pricking, piercing, stretching or incision of the clitoris and/or labia, cauterization of the clitoris and surrounding tissue, scraping or cutting of the vagina or surrounding tissue, and/or the introduction of corrosive substances or herbs into the vagina (WHO 1995).

Changes over time in attitudes, beliefs and practices in several communities that traditionally have upheld the practice have been identified, and marked inter-generational declines in the practice within certain ethnic groups are evident in the KDHS data. The proportion of women cut decreases steeply with age, from nearly one-half of women age 35 years and above to 26 percent of those age 15-19 years. These declines are particularly pronounced among the Kalenjin (62% to 49%), Kikuyu (43% to 33%) and Kamba (33% to 27%).

A 1998 study by the United Nations Children's Fund (UNICEF) and the Program for Appropriate Technology in Health (PATH) found that among the Kikuyu and Kalenjin, Christian families with higher levels of formal education and higher economic status are more likely to favour abandoning FGC. This suggests the importance of socio-economic development and adherence to a Christian church as key factors facilitating this gradual change in behaviour (UNICEF/PATH 1998).

Two groups among whom the practice of FGC remains virtually universal, the Somali and the Maasai, are within the lowest economic and educational levels in the country and are mainly non-Christian; these factors may partly explain the sustained high level of the practice. The Abagusii[2], however, are not only strongly Christian but have also attained some of the highest educational and economic development in Kenya; and yet FGC is nearly universal among them. This study sought to discover factors explaining why this ethnic group continues to circumcise women and girls.

Medicalization of FGC

In most societies in Kenya (as in other parts of Africa), traditional practitioners, such as excisors, traditional birth attendants, healers and medicine men, usually perform FGC. Recently, however, professional health personnel in a number of countries have become more involved in cutting female children (Egypt, El-Gibaly et al. 2002; Nigeria, Mandera 2000). For many, trained midwives, nurses, and other health cadres have taken over from the traditional practitioners and now play an important role in sustaining the practice by 'medicalizing' the procedure. The increased involvement of medical staff in circumcision is thought to be a response to the emphasis on health risks that has characterized anti-FGC campaigns (Shell-Duncan, 2001). Having the procedure performed by trained practitioners, and preferably in a health facility setting, is thought to minimize the health risks and pain while sustaining the practice to meet cultural norms.

According to the 1998 KDHS, one-third of all circumcised women reported being cut by a health worker. Among the Abagusii, this proportion comprises 50 percent of all cut women. Similar findings emerge from research undertaken specifically among the Abagusii by PATH and Maendeleo ya Wanawake (MYWO), in which the proportion of cut women reporting that it was done in a health facility increased from 5 percent in 1993 to 23 percent in 2000 (PATH/MYWO 2000). Yet more evidence of a trend toward medicalization among the Abagusii comes from a study undertaken by the Population Council (Chege et al. 2001) which found that 94 percent of circumcised mothers had been cut by a traditional circumciser, whereas among girls aged 4 – 17 years who were cut, only 29 percent were treated by traditional circumciser. The remainder reported being cut by a nurse or doctor. In addition, while two-thirds of the mothers reported being cut at the traditional practitioner's

[2] This ethnic group predominates in the three districts (Kisii, Gucha and Nyamira) of Nyanza Province in western Kenya that are collectively known as "Gusiiland."

home and only 2 percent at a health facility, only 14 percent of the girls were cut at the home of a traditional practitioner, while 37 percent were cut at a health facility. Moreover, of the 70 percent of girls who reported being circumcised by a medical practitioner, about half were cut at a health facility while the remainder were cut at their own or another home. All the Abagusii mothers were able to report the type of cutting (primarily a clitoridectomy), whereas half of the girls could not describe which type of cutting had been done. This supports anecdotal reports of a move towards cutting less flesh, which may explain the difficulty of the girls in describing the type of cut.

Even when a traditional practitioner cuts the girl, many health personnel in Nyamira District, and particularly the female nurses, reported being approached for tetanus toxoid injections to use after the cutting (PATH/SDA 1996). This demonstrates an increasing concern with the safety of the procedure, as families seek various ways to reduce the likelihood of adverse health outcomes while still retaining the practice.

Although much of the damage inflicted by cutting the flesh of the genitals is permanent, Shell-Duncan et al. (2000) outline a hotly contested debate as to whether medicalization is a valid intervention to address the typically unsafe conditions under which cutting is performed, or whether it counteracts efforts to eliminate the practice on human rights grounds. Moreover, medicalization of the procedure does not address the potential for longer-term psychological, emotional and sexual problems that genital cutting may create.

Consequently, most organizations involved in FGC abandonment have opposed the medicalization of FGC. The World Health Organization (WHO), for example, states, "female genital mutilation in any form should not be practiced by health professionals in any setting – including hospitals or other health establishments." (WHO 2001d). Numerous other organizations have made explicit statements against medicalization, including the International Federation of Gynecology and Obstetrics, the Inter-African Committee, and the U.S. Agency for International Development (USAID).

Efforts to encourage abandonment of FGC and its medicalization in Kenya

There is a long history of vigorous efforts to encourage the abandonment of FGC in Kenya. Efforts began in the 1930s with the colonial administration and Christian missionaries and continued with the involvement of national and international NGOs. Anti-FGC campaigns employed various strategies, including alternative rites of passage for adolescent girls, empowerment of the girl child, public education campaigns, and advocacy programs for women and girls. Key government officials, including former President Moi, have made public pronouncements against the practice and the mass media has increased its coverage of the practice.

At the national level, efforts to eradicate FGC are now reflected in key policy guidelines. In 1999, the Kenyan Ministry of Health (MOH) launched a National Plan of Action for the Elimination of Female Circumcision in Kenya. In 2001, the MOH circulated a policy directive making FGC illegal in all health facilities. Sections 74, 250, and 251 of the current national constitution protect every individual from torture and inhuman and degrading treatment, and have been used to argue that FGC should be seen as an unlawful practice. The Children's Act, enacted in 2001, specifically criminalized FGC. Section 14 of the Act states, "No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health,

social welfare, dignity or physical and psychological development." Section 18 of the Act notes that any conviction for FGC-related offences carries a penalty of 12 months imprisonment or a fine of Kshs 50,000 (approximately US$670), or both.

In the three districts inhabited by the Abagusii, many NGOs and community-based organizations such as PATH, MYWO, the Seventh Day Adventist church, Female Guild Organization, Federation of Women's Groups, the Pan African Christian Women's Organization, Julikei International, and the Coalition on Violence Against Women have initiated efforts to reduce the prevalence of the practice. These organizations have created awareness of the harmful effects of FGC by providing outreach materials and by mobilizing and educating communities through seminars, workshops, public meetings and discussions[3]. Use of the Alternative Rite of Passage has also been actively pursued by PATH and its partners.

Given that it is an emerging phenomenon, little is known about medicalization of FGC or about strategies for countering this trend. One strategy of working directly with health care providers has been used in Mali and achieved some success in educating providers on the adverse outcomes of the practice (Diop et al. 1998). It has subsequently been scaled up within the country, but its effect on reducing medicalization is not known. WHO has developed a series of training materials that can be used to educate health workers on FGC; these are currently being introduced on a limited basis in selected countries (WHO 2000a; WHO 2000b).

Methodology

To provide information to guide the design of appropriate and effective strategies to discourage medicalization while encouraging abandonment of FGC, data were collected to assess the knowledge, attitudes and practices of health providers and the community in general about the medicalization of FGC among the Abagusii. The study used several research methods to understand:

1. The context and motivations underlying the trend of medicalizing FGC.
2. The context and rationale for health providers to decide whether or not to respond to requests from families to cut girls.
3. The community's awareness of the legislative, policy and human rights aspects of FGC.
4. The attitudes and perceptions of providers towards the practice.

In-depth interviews

In-depth interviews were conducted with 48 key informants and 100 health personnel selected from public health facilities (district hospitals and health centers), mission health facilities, and private clinics in the three districts. Key community informants included 15 school board members and teachers, five District Officers, three Education Officers, three Children's Officers, two Assistant Chiefs, one probation officer, seven church elders, four social workers, six traditional circumcisers, and two former nurses now working as traditional circumcisers. The sample of health care workers included 29 nurses, 14 clinicians or doctors, 20 senior medical administrators, 17 support staff nurses, eight nurse aides, two lab

[3] Personal communication with Oloo Habil, Northern Aid.

technicians, six midwives, and two community health workers. Interviews were conducted in private inside or near the health facility where the respondent worked. The data collection instruments were developed in English and translated into the Ekegusii and Swahili languages for ease of understanding the local meaning of terms.

Focus group discussions

Ten focus group discussions with 8-10 members each were conducted in each of the three districts with four population sub-groups: parents of girls who were recently past the age of cutting; adolescent girls who were recently past the age of cutting; young married women with a girl-child; and young married and unmarried men. For the sub-groups of girls and women three further categories were created to allow comparisons to be made among those who do not practice FGC,[4] those who practice FGC with traditional practitioners, and those who practice FGC with medical practitioners.

Parents of girls who were recently past the age of cutting were included because they could provide information about current attitudes regarding FGC. Adolescent girls recently past the age of circumcision were interviewed to contribute the views of the most recent generation to be directly involved in medicalization. Young married women with a girl-child were included because they could discuss the influence of their cutting status on their sexuality and prospects for marriage and marital life. In addition, they had experienced the health system through antenatal care, which enabled them to comment on health providers and their attitude towards FGC. They could also discuss their intentions concerning cutting of their current and future daughters. Young men were interviewed to assess their views and attitudes towards medicalization and commercialization of the practice. Their perspectives were seen as important in deciding if and how the practice continues.

Participants for the focus groups were recruited from their homesteads using the "snowball/contact-tracing" method. Only participants from the Abagusii community were included and they were grouped by sex with a moderator of the same sex. Discussions lasting about two hours were conducted in Kiswahili, English or Ekegusii depending on the respondents' preferences. All study participants were informed of the need to tape-record the interview and discussion, and prior verbal consent was obtained.

Interviews with health care providers

A listing of all public and private health facilities in the three districts led to the identification of 139 facilities that were registered and working, and interviews were conducted with staff working in these facilities. Over half of these were government facilities, one-fourth of them privately run and one-fifth managed by faith-based organizations. Among the facilities visited, 35 percent were district hospitals, 24 percent health centers, 14 percent sub-district hospitals, 13 percent private clinics, 7 percent dispensaries and 7 percent nursing homes.

[4] In this context they can be considered "positive deviants." The term deviant here is not pejorative but refers to someone who for a variety of reasons, has not yielded to societal norms or pressures, but has deviated from them in a positive manner. In this usage, to deviate means not to cut or has not been cut and includes girls who have refused to be cut or individuals who have prevented the cutting of young girls (CEDPA-Egypt 2000).

In total, 727 service providers were interviewed.[5] Of these, 54 percent were interviewed in government health facilities, 26 percent at private clinics, and 19 percent from faith-based facilities. One third of the respondents were registered or enrolled nurses, 18 percent support staff, 14 percent lab technicians or pharmacists, 12 percent nurse aides, 7 percent clinical officers, and the remainder were other types of employees. Forty percent were male and 60 percent were female. Two-thirds of the providers said that they had always worked within the same district, while one-third had either transferred in from another district or worked across the border in Tanzania or Uganda.

Interviews with mothers of girl-children aged 10 years and under

In addition, 659 ANC clients at the health facilities who were mothers of girl-children aged 10 years and under were interviewed after their consultations. About 49 percent of the women interviewed were at the district hospital or sub-district hospital, 24 percent at a health center, 20 percent at a private clinic or nursing home, and 7 percent at a dispensary. The majority of clients and providers were under 35 years of age, currently married, and members of the Adventist church. Selected socio-demographic characteristics of these women, and of the service providers, are presented in Table 1.

Table 1. Socio-demographic characteristics of interview participants

	Service providers			Exit clients
Age Group	**Male**	**Female**	**Total**	**All female**
	n=293	**n=434**	**n=727**	**n=659**
< 25 yrs	13	22	18	31
25-29 yrs	20	16	18	31
30-34 yrs	17	13	15	19
35-39 yrs	10	11	11	11
40-44 yrs	17	17	17	5
45-49 yrs	12	14	13	2
50+ yrs	10	7	9	1
District				
Kisii Central	45	45	45	37
Nyamira	33	33	33	32
Gucha	22	21	22	31
Religion				
Catholic	30	31	30	35
Seventh Day Adventist	46	49	48	48
Pentecostal	14	10	12	13
Other	11	10	10	5
Marital status				
Single/Never married	24	29	27	12
Currently married	74	68	70	85
Formerly married	0.3	2	2	4
No response	2	1	1	-

[5] This large number of providers was interviewed because this study was intended to be the baseline survey for an evaluation of a provider-oriented intervention (to be implemented by PATH through the USAID-funded PRIME II Project) to engage them in encouraging FGC abandonment. Unfortunately, funding for implementing the intervention was no longer available after completion of this study.

Table 1. Socio-demographic characteristics of interview participants (continued)				
	Service providers		**Exit clients**	
Education attained	Male	Female	Total	All female
Informal /pre-primary	2	1	2	6
Incomplete primary	3	3	3	25
Complete primary	10	5	7	22
Incomplete secondary	9	9	9	18
Complete secondary	24	26	25	20
College/University	54	56	55	9
Non Response	-	-	-	1
Qualification				
Medical personnel	33	44	40	-
Technical staff	22	9	14	-
Administration	15	28	23	-
Subordinate staff	30	20	24	-
Employment Status				
Employed	-	-	-	43
Unemployed	-	-	-	57

Mystery clients seeking FGC information or services

Box 1. Mystery client scenario

A middle-aged woman comes to the facility seeking information about the advantages and disadvantages of cutting her daughter or granddaughter. It becomes apparent that she is not sure if she wants her girl to be cut or not. Her family is pressuring her and she is uncertain, confused and indecisive. She would like more information on female circumcision and mostly, advice on what to do.

A total of 23 simulated, or mystery, clients were recruited and trained, with each 'client' visiting five to seven providers from whom they requested advice concerning a planned circumcision of her daughter or granddaughter, according to the scenario described in Box 1. The persons posing as a client were trained to pay careful attention to the provider's knowledge, advice and attitude towards the practice, and were interviewed shortly afterwards to record their description of the interaction. In total, 139 visits were carried out, 60 with male providers and 79 with female providers. Of these 139 visits, 49 were at public clinics, 2 NGO, 64 at private centers, and 24 at mission facilities.

Data management and analysis

All names and other potentially identifying information were removed from the data collection instruments, and all audiotapes and written transcriptions were placed in a locked cabinet during and after fieldwork. All transcripts were translated from Ekegusii or Kiswahili into English directly after the interview or group discussion, and double-checked by the supervisors and Principal Investigator to assure consistency in meaning. Transcripts/notes were entered and stored on computerized data files at the Population Council office in Nairobi. Coding and analysis of the qualitative data were carried out using Atlas.ti software. Quantitative data were entered using Epi Info and data were analyzed using SPSS.

Findings

Justification for FGC

Several reasons emerged as to why the Abagusii continue practicing FGC. The predominant reason, from qualitative and quantitative data, was that FGC fulfils Abagusii customs and traditions that are deeply entrenched, especially among the older generation. Parents of circumcised girls spoke strongly of the importance of FGC as a cultural identifier of a member of the minority Abagusii community, distinguishing their daughters from their majority Luo neighbours who do not circumcise women.

A circumcised woman was said to be mature, obedient, and aware of her role in the family and in the society, characteristics that are highly valued among the Abagusii. Survey participants also cited the need to control a woman's sexual desires before marriage and to ensure fidelity, especially within polygamous marriages. In focus groups with mothers of girls already cut, one mother said that "after 40 years, circumcised women lose interest in sex." Another said, "For circumcised women, sex is for procreation."

Marriage is considered an opportunity to attain identity, status and respect, but it was thought that uncut women would find it difficult get married. A clan elder in Kisii said, "If an Abagusii girl is not circumcised, she can never be married and she is never let to stay with others who have been circumcised. She's isolated and some people say she can never get children." Thus, circumcision will help a girl get married and her family to negotiate a better bride price. For some, therefore, FGC is practised as a means to improve the daughter's marriage prospects. Others felt that it confers respect and a sense of belonging and prepares a girl for marriage, as seen in responses in Box 2.

Box 2. Reasons for circumcision given by community members

--When circumcised, the girl's age mates will respect her more.

--Circumcised girls act mature and when married are faithful.

--Circumcised girls feel they belong to the community.

Historically, the ceremony surrounding the cutting itself was considered an important event, bringing families together to celebrate with festivities, food, music, and dancing. But with the recent government ban on FGC, as well as increasing costs, these festivities are less frequent and elaborate. Having to undertake the cutting in secrecy means that only close family members are invited, so the celebrations are smaller and carry less social significance.

Concern with genital hygiene and cleanliness was another reason given. One traditional circumciser in Nyamira said, "That thing of theirs looks like a crow's beak and it should be removed so that washing the vagina is more easy."

Over 40 percent of the providers and women interviewed felt that uncut girls are viewed negatively compared with circumcised girls, being stigmatised, shunned and discriminated against. This was also mentioned in discussions with older women.

Younger girls were not clear about the reason for circumcision. One girl in Gucha who had been cut in the traditional manner said that it was "to satisfy parents; culture says we should be circumcised, to become an adult." A circumcised girl in Nyamira said it was "to get

married, to avoid stigma and discrimination from peers, family members and neighbors." Such answers suggest that for these younger girls, the cut is something they have to do and not something they want or understand.

Changes in the practice

Age at which girls are cut

"What I see is that girls are circumcised when very young, even those who are extremely young ….. When we went for circumcision, we were all big girls above the age of 17 years, that time we were not timid unlike today."

--Health Nursing Officer, Nyamira

One widely mentioned change was that girls are now being circumcised at earlier ages. Traditionally, they were circumcised when almost ready for marriage, from age 15 onwards. Girls as young as six are now reportedly being circumcised, though the most frequent age is between eight and ten. Chege and colleagues (2002) found a median age of nine years in their sample of girls. However, interviews with the girls' mothers reported a median age of 10 years, which suggests that the age of cutting may not actually have changed much over the last generation. Cutting at the age of marriage has probably not occurred for at least two generations.

Chege et al. (2002) found that among the Abagusii, the timing of the cut need not be directly linked with transition through puberty. Thus, cutting is not normally an integral part of the traditional rite of passage, but a cultural definition of being a female Abagusii. As such, it should be undertaken some time preceding the transition to adulthood. Some respondents believed the younger girls are better able to survive the painful experience and that their healing process is quicker. Some survey respondents also believed that younger girls are easier to manipulate as they are not mature enough to grasp the gravity of the situation. A midwife in Nyamira said, "They cannot leave the girls to be mature because at this age, they would know their rights and refuse, so they must circumcise them at an early age, before they know the disadvantages of female circumcision."

Table 2. Decisionmaker on when a girl is cut, according to providers and clients (%)

	Providers n=727	Clients n=659
Mother	62	63
Father	20	26
Grandmother	11	3
Other	5	7
Don't know/no response	1	1

Though other relatives have some influence regarding when a girl is cut, it appears to be the mother who usually decides when a girl should be circumcised (see Table 2). Group discussions gave examples of unwilling girls, and even married women, being forced to undergo the ritual after the usual age; such is the extent of the pressure, especially from the mother and older female relatives.

Type of cut

There appear to have been significant changes in the type of cutting now being done. As stated by one clinical officer, "What happens is that [respondent sighs] the medical field advises that if one has got to be circumcised they will just prick the clitoris, blood comes out and psychologically you think…I mean the girl thinks… 'I am now a woman, I will not be despised by others'…." Over 80 percent of respondents, both providers and exit clients, reported that compared with 10 years ago, less of the genitalia is cut and the procedure is less painful, but the cost has increased.

The majority of providers and clients reported that part of clitoris is normally removed (see Table 3). However, as one respondent mentioned, this "depends on where and who does it." Pricking or nicking of the tip of the clitoris seems to be a recent and increasingly popular procedure, carried out mainly by health staff, which nurses call "psychological circumcision."

Table 3. Reported type of cut, according to clients and providers (%)

	Providers n=727	Clients n=659
Part of clitoris removed	76	78
Pricking or nicking the clitoris	11	9
Whole clitoris removed	3	4
Excision of clitoris and part of labia minora	-	2
Don't know or no response	14	11

Some providers then bandage the cut to help it to heal quickly. In most cases, no tissue is removed but blood is drawn to give the impression of a cut being made, unless the parent or guardian insists on tissue cutting. Most young women interviewed had difficulty describing exactly what had been cut. Older women, by contrast, were happy and proud to give an explicit description of the type of cut they had undergone.

These responses support the findings by Chege et al. 2002 in which virtually all newly cut girls and their mothers from the Masaai and Meru communities could describe the type of cut, as could mothers from the Abagusii community, but half of the Abagusii girls interviewed could not describe the type of cut. If indeed the current practice were primarily restricted to a nick or pricking, then this would explain the difficulty girls have in describing what was cut.

"It has changed because you know they used to chop everything on the top. Now with time, a person says just remove a bit to satisfy people."

--Young married woman with girl infant, Kisii

Persons performing the circumcision

Providers and clients of all ethnic groups frequently cited nurses and midwives as performing FGC. However, the Abagusii respondents were much more likely to associate nurses and midwives with circumcision, reinforcing the importance of this group among the Abagusii.

Table 4. Most likely provider of FGC, according to providers and clients (%)

	Service Provider		Client	
	Abagusii n=607	Non-Abagusii n=108	Abagusii n=623	Non-Abagusii n=36
Nurse/Midwife	73	48	89	69
Traditional Circumciser	12	29	4	3
Doctor/Clinical officer	2	1	1	-
Nurse aide / support staff	6	8	2	3
Traditional birth attendant	-	7	-	-
Retired medical staff	4	2	1	3
Don't know or no response	3	7	1	14

Indeed, almost 90 percent of women interviewed reported this category. Other cadres of health staff, including retired female medical staff (often termed *abangina abanyagitari*) were also mentioned as circumcisers. During the 1998 KDHS, 42 percent of circumcised Abagusii women aged 15-49 years reported that they had been cut by a nurse or midwife and 39 percent reported being cut by a traditional circumciser. These findings suggest that since

1998 there has been a rapid increase in the use of nurse/midwives as the main persons undertaking the practice, with a sharp decline in the role of traditional circumcisers.

According to over 70 percent of the respondents, this preference for medical staff has emerged over the last 10 years. The reasons explaining this were varied. Fear of infection and preference for "professional" providers were the most commonly cited reasons. The clean environment at the hospital or clinic is preferred. A girl is admitted like any other patient and the medical personnel use sterile implements for the operation, reducing the chances of infection. The amount of tissue cut by medical staff is less, so there is less risk involved and it is felt that providers will take precautions to prevent infection and use local anaesthesia to reduce pain. Girls are usually vaccinated against tetanus and sometimes given medicine, according to six recently cut girls interviewed at a clinic. They reported that the nurse had injected them individually with a different needle and cut each with their own razor. One girl in Nyamira said, "It was not painful and the nurse took good care of me. After two days of resting, my auntie came to pick me up."

Table 5. Main reason why medical staff carry out FGC, according to providers and clients (%)

	Providers n=727	Exit clients n=659
Money or gifts	62	67
Provide safe/hygienic procedures	11	9
Prevent health complications	7	6
Community/social pressure	6	5
Traditional/cultural demands	9	7
Other	2	-
Don't know or no response	4	6

With medicalization, the practice appears to have become more commercialized. Financial remuneration or other material gifts are perceived to be the primary incentive for medical staff agreeing to cut girls (see Table). In addition, however, there is sometimes pressure from the medical staff's community, especially relatives, to respond to requests as a way of demonstrating respect for Abagusii cultural values and upholding customs and traditions.

Study participants also pointed to educational campaigns against HIV/AIDS as a factor in the medicalization of FGC. These campaigns have pointed out the risk of transmitting HIV or other infections through a commonly used knife or non-sterilized blade. Additionally, those who take their children to medical providers are thought to be more "modern," as they have discarded old-fashioned ways of circumcision.

"I know this is against my profession as a nurse, but I couldn't refuse the request by a relative. That's how I started performing the operation."

--Nurse, Nyamira

However, the traditionalists felt that this trend to medicalization debases the rationale for female circumcision. One traditional circumciser in Gucha remarked, "I wonder if a child cannot feel pain, [how] can she become mature? In the past a girl would bleed but those medical personnel just cut a small thing and there is no bleeding." The site of the cutting is also symbolic. There is a special stone situated near the granary or in the banana plantation where the girl sits with her legs astride, being held by an assistant to the traditional circumciser while being cut. Such sites symbolized the initiate's fertility. Some traditional circumcisers are concerned and annoyed that "immature" and "unprofessional" young nurses are spoiling this tradition. "Look at those young girls at ------- Nursing Home; [they] have spoiled our customs, they are not supposed to do it," said a

traditional circumciser in Kisii. " Even male non-Abagusii people can do the cutting." One mother whose daughter had been circumcised in the traditional way remarked that, "these girls who are cut in the hospital are just like the Luo. I think our customs are being trampled up. The Omogusii distinctiveness is fast disappearing."

Although the majority of the respondents reported that it is the duty of women to circumcise girls, some male health workers are reportedly undertaking the procedure. However, the respondents differed as to whether the person doing the cutting is from the Abagusii community or not. About a third of health providers felt that the circumciser should be an Abagusii, whereas about a quarter of them believed that a medical practitioner from any ethnic community would be acceptable, so long as they were experienced in performing FGC.

Although community members said that it is mainly providers who presently perform FGC, only 6 percent of the providers interviewed admitted that they had carried out the procedure (see Table). When asked what they did when requested most said that they tried to counsel the mother or just refused. Many felt, however, that there was no harm in the kind of FGC practiced by providers because "…we promote the initiation ritual in a more modernized way and in a more hygienic and safer way." During group discussions, community members also revealed that nurses do FGC secretly in the wards without the knowledge of the facility managers; in such cases, girls are admitted for other ailments but actually have come for FGC.

Table 6. Providers' reported responses to requests for circumcision (%)

	Providers n=723
Carried out the procedure	6
Referred to known practitioner	10
Tried to counsel, did not do it	44
Refused to do it	38
Other	3

During the visits by mystery clients, 30 percent of the providers supported FGC and of these, 19 percent suggested that they could undertake cutting in the facility or refer the girl to another clinic, saying that "everyone is doing it." Some offered pricking to psychologically satisfy the girl that they had undergone the cut when actually they had not. Encouragingly, over two-thirds of the providers (68%) advised the mystery clients to bring the girl in for advice *against* FGC, insisting that it is a personal decision. Others pointed out there were alternative means of initiation without necessarily undergoing the cut.

It also became evident that health facility personnel, who are not medically trained or adequately knowledgeable about medical procedures, are undertaking it for financial rewards. Discussions with both providers and community leaders show concern about this trend. The community's judgment of whether a person is medically qualified is usually based on their conduct, way of dressing, and place of work, rather than on proven credentials. One focus group participant described the person who cut her daughter by saying, *"... I think she was a nurse, she used to work in the maternity ward and wore a white coat*." Many community members do not know that it is not only medical staff that wear white coats as other support staff can sometimes wear white coats as part of their uniform; many community members call everyone in a white coat that works in the health system *daktari* or 'doctor'.

Time and place for the procedure

Traditionally, female circumcision among the Abagusii has taken place towards the end of the year, often in late November and early December, when schools have closed. This gives girls enough time to recuperate, and as it is also after the harvest, plenty of food and money are available. As it is the time of holiday festivities, many relatives will have travelled back home and so could participate in the celebrations. Since being outlawed, however, the August school holiday period has become an increasingly popular time for cutting because the local chiefs and police are known to be looking for cases during the month of December.

It was reported that some health providers take a month's leave at this time and build temporary sheds to act as a makeshift "clinic" in their community. Parents appear to prefer to use this arrangement, as it is safer, less expensive, and easier to keep secret. As several providers pointed out, these clinics can see as many as 50 girls per day and the providers have to be paid by the child's parents or guardian. The procedure is usually carried out during the night or at dawn to reduce the chance of detection.

Parents wanting their daughter to be cut by a health provider at a clinic normally negotiate directly with them. The girl is then admitted to the facility, often under the pretext of an ailment such as malaria. She can stay for anything from three hours to one week, depending on the type of cut being done. However, most are 'pricked' and discharged, and only in a few private clinics do the young girls stay for a day or two.

Table 7. Place FGC is most commonly performed, according to providers and clients (%)

	Providers n=727	Exit clients n=659
Girl's own home	63	51
Private clinic	18	30
Health provider's place	2	2
Public health facility	6	12
Makeshift place	3	2
Trad. practitioner's place	3	1
Other	1	1
Don't know or no response	3	1

Most respondents, however, indicated that providers are usually invited to the girl's home to perform the procedure (see Table 7). The circumciser is often invited at night and all the prospective initiates assemble where the circumciser is, often at one girl's home. The nurse carries out the circumcisions and there is no feasting or celebrations to maintain the secrecy.

The procedure

Many of the rituals and ceremonies that used to accompany circumcision as part of a rite of passage have disappeared. For instance, a fire, once kept burning during the entire seclusion or healing period to guard the girl's fertility, is no longer lit. Such traditions as cutting in groups and spending a period of time in seclusion are also disappearing, attributed to fear of sorcery; some families fear that crowds of initiates may provide avenues for malevolent forces to gain entry into the lives of the initiates. Moreover, with the government ban on FGC, group procedures are harder to organize.

Over 70 percent of the providers and antenatal care (ANC) clients reported perceiving that girls prefer to be cut individually and in most cases, prefer the medical cut (see Table 8). Moreover, three-quarters of the service providers thought that girls who are medically cut are viewed as equal with their traditionally cut counterparts. During group discussions, one nurse remarked, "the circumcision of girls is just for confirmation of the traditions and personal satisfaction, if locally done or at hospital, it is the same." Another provider noted, "It's not something that girls make public and nobody needs to know."

Table 8. Circumstances in which a girl is cut

	Providers n=721	Exit clients n=653
Girls prefer being cut individually	74	79
No ceremony accompanying girl's circumcision	39	33
People prefer daughters to be medically cut	87	92

However, some participants said that the medical cut is not viewed the same as the traditional cut. Traditional circumcisers were opposed to medicalization because they fear losing prestige associated with the cultural practice. The majority of older women interviewed were convinced that the medicalized cut does not have the same meaning as the traditional cut and considered it inferior for several reasons:

- There is less pain with the medical cut, and experiencing pain is a vital component of the ritual as it prepares girl for the pain of childbirth and adversities of adult life.
- There is no traditional training needed for the medical cut, and it is not done the 'right way' (does not follow the *kimila* customs of the Abagusii).
- Girls cut medically are viewed as immature (*isagane*, a derogatory name).
- "Immature" and "unprofessional" young nurses undertaking the cutting were spoiling the tradition of the procedure.

Instrument used

A variety of instruments are used, but by far the most common is a razor blade provided by the girl's family, followed by scissors and clinical scalpel. Over three-quarters of respondents felt that the instruments were sufficiently clean. When asked how the cutting instruments were cleaned, over half of the respondents reported that the blade is used and then disposed of.

Table 9. Instrument reportedly used for cutting, according to clients and providers (%)

	Providers n=727	Exit clients n=659
Own razor blade	80	84
Scissors	20	33
Clinical scalpel	19	14
Shared razor	6	3
Common knife	4	2
Other instrument	8	3
Don't know or no response	7	4

Price charged

Both providers and clients reported that the cost of FGC ranges between 150 – 500 Kshs (US$ 1.90 – 6.25) per girl. The medical cut is more expensive than the traditional cut, which can cost as little as 50 Kshs ($0.60) without the girl's own razor and other amenities. Despite the health providers' higher prices, parents or guardians prefer to take their daughters to be medically cut (according to 87% of the providers and 92% of the clients) because of the value attached to doing the practice safely and hygienically.

Social perceptions of uncut girls

Table 10. Reasons not to practice FGC		
	Providers n=727	Exit clients n=659
Know it's not necessary	44	48
Know the harmful effects	31	25
Against religious beliefs	16	20
Other	5	4
Don't know or no response	3	3

A number of families have recognized that FGC is harmful, and are not having their girls cut, even though the majority around them continue the practice (see Table 10). Two-thirds of the health providers and half of the ANC clients interviewed knew of such families. These families, who are openly making a stand to not cut their girls, are perceived to consider female circumcision unnecessary, against their religion, and harmful. Several respondents believed that whether a woman is circumcised or uncircumcised is becoming less of a criterion for marriageability (see Table 11).

Table 11. Men's reported preference in marriage according to providers and clients (%)		
	Providers n=727	Exit clients n=659
Circumcised woman	30	36
Uncircumcised woman	23	15
Either, doesn't matter	40	44
Don't know or no response	7	6

During a group discussion among young unmarried men, most respondents felt that they would not have a problem marrying an uncircumcised girl. A young unmarried man in Kisii said, "It is women who insist on that." Another remarked, "Many Gusii men are now marrying girls from neighboring non-circumcising communities." Women, especially older women, continue to be the primary custodians of the practice. In interviews, many older women insisted that they knew what their sons, as future husbands, would like, and they did not want their daughters to stay unmarried.

Conflicts about society's view of FGC remain. Although the majority of respondents said that families and girls who did not practice FGC would not be viewed differently from those who continued the practice, responses to survey questions showed that many participants still felt that the uncircumcised girls would be viewed negatively (see Table 12).

Table 12. Providers' and clients' view of how society sees uncut girls (%)		
	Providers n=727	Exit clients n=659
No difference	61	66
Respected	4	7
Role model	5	5
Mature	1	2
Immature	17	13
Marriageable	2	4
Unmarriageable	7	5
Educated	9	10
Disrespected	22	20
Mistreated	5	4
Shunned	24	18
Other	4	1
Don't know or no response	1	2

Risks Associated with FGC

Physical problems

Table 13 Specific health risks cited by providers and clients (%)	Providers N=443	Exit clients N=547
Physical pain	47	62
Prolonged labour	85	25
Excessive bleeding/anaemia	85	89
Shock	22	11
Painful menstruation	3	1
Difficulty urinating	9	9
Vesico/recto-vaginal fistula	11	2
Still births	9	6
Keloids/scarring	46	20
Gangrene, septicaemia & tetanus	33	17
Perineal tears	36	18
Contracting HIV/AIDS	72	59
Painful sexual penetration	11	5

Both providers and clients interviewed knew that FGC can cause physical, psychological, and social problems (see Table 13). The majority of ANC clients (83%) and of service providers (61%) knew some of the health risks associated with FGC, especially physical pain, excessive bleeding, and exposure to HIV. Service providers also mentioned prolonged labour, perineal tears, gangrene, septicaemia, tetanus and scarring as other risks associated with FGC. Most well known were the immediate complications during the cutting itself, which is not surprising as most of the other complications are more common with type 2 and 3 cuts than with the type practiced among the Abagusii.

During in-depth interviews, many female respondents described pain and excessive bleeding (due to accidental injuries) as the main risks. In the past, if a girl cried in the process of being cut she could be detained until her family brought a goat to the circumciser for cleansing. In the traditional setting, if a girl bled badly 'traditional' methods were applied to stop the bleeding (for example, asking a woman who had had sexual intercourse the previous night to stand astride the girl to stop the bleeding). The severity of infections was perceived to vary, depending on who carried out the circumcision and where it was done. Interview participants mentioned such infections as tetanus and HIV. They also mentioned problems arising during delivery, including incontinence due to fistulas and difficult birth. A midwife in Nyamira said, "Mostly during delivery, you know there is a difference between a circumcised and an uncircumcised woman. For many women who are circumcised, during delivery we cut deep to allow the head of the baby to come out."

Psychological and social problems

Both ANC clients and providers knew of psychological problems and social problems associated with FGC (see Table 14). Problems mentioned most frequently were trauma and depression (over 80%) and marital conflict (over 60%), although the latter was felt to be related with lack of sexual satisfaction stemming from the cut. Suppression of female

Table 14. Psychological and social problems associated with FGC, according to providers and clients (%)		
Psychological problems	Providers n=104	Exit clients N=603
Fear of sexual penetration	7	12
Trauma and depression	87	82
Lack of sexual satisfaction	19	24
Other	4	7
Social problems		
Marital conflict	73	64
Encourage early marriages	33	25
Against women's dignity	15	23
Limits education of girls	15	15
Against religion	16	13
Other	2	14

sexual desire is an important reason for FGC. “The aim of circumcising girls in Abagusii is to cool them, so that they don't start sex early,” said a church leader in Nyamira.

Human Rights, Law & Policy on FGC

Understanding rights and FGC

Approximately half of the ANC clients and 61percent of the providers interviewed agreed that FGC contravenes girls’ rights. Responses during in-depth interviews also indicated a good grasp of several human rights as they relate to FGC:

> *--There is the issue of not making a decision of her own because mostly the young girl is restricted not to.* (Social Worker, Kisii Township)

> *--I think that the right of this girl to be healthy is deprived because she can get infected or gets long-term effects, for example [a fistula].* (Medical Officer, Gucha)

> *--Some married women who are cut complain that she doesn't enjoy her sex, she doesn't get sexual satisfaction, and she is deprived of her rights.* (Clinical Officer, Kisii)

> *--The right of living. If a young girl bleeds to death, the person performing the circumcision is the one to be blamed.* (Young unmarried man, Kisii)

> *--We know the risks involved and that one might lead to bleeding and even death, I think everybody has a right to live. When a young person is exposed to circumcision which will endanger her life in future it is infringing her rights.* (Enrolled Community Nurse, Kisii)

> *--The freedom we deny them is that the girl will not continue with education. When circumcised, she is now a "mokabamura" (a girl who is no longer a child), she now begins thinking of when she is going to get married and the moment breasts develop, she runs off. Actually if you look carefully around here in Gusii, you find very young girls having babies and a majority of them are not educated.* (Church leader & Catechist, Nyamira)

> *These ladies once circumcised they were supposed to get married and not to continue with education. Now their right of continuing with education is curtailed.* (School headmaster, Gucha)

A few respondents felt that FGC does not contravene a girl or woman’s basic rights. They saw it as a cultural practice to which all Abagusii ascribe and as such it is a right to be cut that should not be denied any Abagusii woman:

> *There is no way a Kisii woman can be accused of violating her rights by being circumcised, if anything, she is upholding her right as a Kisii woman.* (Women’s group leader, Gucha)

> *It is the right of the girl to be circumcised to avoid the ridicule of being called names*. (Medically circumcised girl, Nyamira)

Knowledge of polices and the legality of FGC

A variety of factors may be influencing public attitudes towards FGC. In addition to the knowledge that FGC is illegal, intensive awareness activities, the government ban on FGC, the introduction of the National Plan of Action for the Elimination of Female Genital Mutilation in 1999, guidelines by the Ministry of Health, the 2001 policy directive making FGC illegal in all health facilities and the recent Children's Act may also have contributed to the gradual shift over time. Most of the service providers see the practice as declining, but many feel that the practice has actually gone underground and is now being carried out secretly. Community members reported that increased numbers of girls who are now openly refusing the cut, that traditional circumcisers have reduced the practice, and that many have reverted to working as herbalists traditional birth attendants. Moreover, the number of girls being cut at clinics has declined and the cutting that is done goes on in secret. "Raids" by chiefs and their deputies to arrest practitioners have been intensified. A clinical officer in Kisii reported, "The chief has started announcing that those caught circumcising girls will be imprisoned. They have employed people to check this and many people are fearing female circumcision."

However, public understanding of the legal aspects of FGC is incomplete. Interviews showed that a substantial proportion of both ANC clients and providers did not know of the 1999 National Plan of Action for the Elimination of FGC, or of the Children's Act of 2001, which criminalizes FGC (see Table 15). In recent months there has been an increased interest among local NGOs in the human rights perspectives of FGC, rather than on the health perspective that guided most previous activities. For example, the Female Guild Organization, working in Mosocho and Kiamokama, Masaba divisions, is now advocating for the rights of girls in schools and the community, and the Coalition on Violence Against Women is working with law enforcement agents and health care providers in Mosocho and Kisii Central.

Table 15. Providers and clients who know of recent Kenyan legislation related to FGC (%)

	Providers n=727	Exit clients n=659
The Children's Act of 2001	48	25
The National Plan of Action for FGC Elimination, 1999	40	21

One-fifth of service providers and ANC clients, especially in the Nyamira district, were not aware that FGC is illegal in Kenya, probably because the criminalization is relatively recent, but also because implementation of the existing law is not clear. For example, according to one senior police officer interviewed:

> *--As far as FGC is concerned, the government has not come up with a specific action on what should be done. I think it is a proposal that all women should not be circumcised. Right now it's optional. Somebody can do it or not. It is good for the government to spell it out clearly so that we can implement the law effectively.*

Table 16. Providers' and clients' perception of the legal status of FGC (%)

	Providers n=727	Exit clients n=539
Proportion thinking that FGC is legal	12	18
Policies or legislation related to FGC	44	N/A
Government has banned FGC	91	90

Only 9 percent of providers know of at least one document[6] that talks about FGC as a violation of human rights and children's rights.

Several informants thought that leaders were not taking an active role in advocating zero tolerance for FGC, accusing some of being poor role models as "they circumcise their daughters back home." It was felt that the community has not been well sensitized on the reasons why the government banned FGC, and that even people who knew of the ban were not taking it seriously as no circumcisers have been prosecuted for circumcising girls. "Nothing has changed, even after the Chief mentioned that it is illegal to circumcise underage girls, we still see it happening in the village," said a local opinion leader in Nyamira.

Some even thought that the ban was a hoax. A traditional circumciser in Nyamira said, "The government has banned FGC but remember, it was Moi who banned FGC, Kenyatta did not, President Kibaki has not. People are lying that there are laws against FGC, that is lying and cheating. It is a must girls should be circumcised. Even in death, the corpse will be circumcised before burial. What law can stop that?"

This laxity and suspicion of the law was blamed on unclear policies, and a lack of sensitization and advocacy. Many community leaders and government employees have not seen any written document on these policies and laws and therefore do not pass the directives on to their communities as expected:

> *--One cannot discuss something they do not clearly know about. Changing a cultural practice like FGC is very difficult and the government should assist us to enforce this law by giving the necessary information and skills.* (Hospital superintendent, Kisii)

> *--We cannot fight the community on this if we ourselves are ill equipped to explain why it should be stopped.* (Community leader, Nyamira)

> *--I haven't seen the government coming out strongly on this, they just say don't go out and practice it…. it is only the religions and NGOs that are active, holding seminars and workshops.* (Clinical officer, Kisii)

> *--Passing the law is not enough, the government should seek to put it into effect.* (Headmaster, Gucha district).

This lack of understanding on how to communicate the government's position against a cultural norm has deterred community and local administration's active participation in enforcing the laws and policies on FGC.

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[6] Such documents include the Convention on the Rights of the Child, the Convention for the Elimination of all Forms of Discrimination Against Women, the African Charter on Human & People's Rights, the Children's Act 2001, and the National Plan of Action for the Elimination of Female Genital Mutilation.

Future of FGC

Intention to circumcise daughter

Over half (52%) of mothers with girl-children aged 10 years and under did not intend to circumcise their daughters, with only 39 percent intending to cut, while 7 percent were not sure. The majority of those intending to cut see FGC as a good tradition, while most of those intending not to cut indicated that the practice has lost its significance (see Tables 17 and 18).

Table 17. Mothers' reasons for intending to cut their daughters (%)

	Exit clients n=265
Good tradition	77
Prevents immorality	30
Confers respect to girls	28
Better marriage prospects	18
Brings honour to family	15
Hygiene / cleanliness	6
Gifts are received	4
Improves fertility	3
Religious demand	2
Other	10

Furthermore, of those intending to circumcise their daughters, 41 percent preferred that their daughters be cut at home and 33 percent preferred that it be in a private clinic, because of lower costs and the ability to pay either in a series of payments or through in-kind gifts. Practitioners also prefer the client's home because of the privacy, and because the money received does not have to be shared with other clinic staff.

Table 18. Mothers' reasons for not cutting their daughters (%)

	Exit clients n=344
Lost its significance	19
Painful experience	15
Bad tradition	14
Health complications	13
Against religion	11
Heard messages against it	10
Limits education	8
Against women's rights	8
Psychological consequences	7
Know alternative rite of passage	3
Other	4

Effects of sensitization and advocacy campaigns

The media, religious leaders, community workers and chiefs' *barazas*, or community meetings, are important sources of information about FGC to community members (see Table 19). Over 80 percent of respondents felt that these messages have led to changes in attitudes and practice. Most of these changes are thought to have occurred in the last 10 years and are most likely to be associated with the increased governmental and NGO anti-FGC activities in the area, the general concern about exposure to HIV and, most recently, the government ban.

It is felt that these sensitization and educational activities have made community members more aware of risks associated with FGC, but have probably also led to medicalization. A clinical officer in Kisii explained, "Campaigns have made members of the community rethink the value of circumcising girls, as they do not want to take unnecessary risks with their daughters and as a result, those still circumcising their girls have mostly made the decision to cut their daughters in a way that reduces the physical harm." The sensitization may also have led to continuation of the practice, but in a reduced form; for example, a nurse in Nyamira says, "If people have moved

Table 19. Source(s) of anti-FGC information, according to providers and clients (%)

	Providers n=688	Clients n=538
Media	81	79
Religious leaders	51	54
Educational materials	26	15
Health providers	25	13
NGO	24	15
Chief's barazas	23	23
Seminars/workshops	16	7
Community leaders	16	15
Community workers	10	31
Relatives	3	5
Retiring of circumcisers	3	2
Other sources	3	4

from the severe cut to clitoridectomy, why can we not move a less painful cut – like the nicking we are doing?"

Overall, the majority of clients (84% of 467 interviewed) said that the practice is declining. The most common reasons for this change included the medicalization of FGC (38%), the social acceptance of uncut girls (37%), and men's willingness to marry uncut girls (30%).

Role of providers in FGC abandonment

In interviews and focus group discussions, researchers sought to clarify the role of providers as potential change agents. Only 43 percent of the providers reported ever having discussed FGC with their clients, and of these, over half reported having difficulties because they did not feel competent enough – only one-quarter had read materials about FGC. However, 86 percent indicated a willingness to influence their colleagues and community (see Table 20). It was felt that their efforts would be more successful if providers who do cut girls were prosecuted. As one provider declared, "you cannot preach water and drink wine."

Table 20. Providers' knowledge and attitudes regarding abandonment of FGC (%)

Percentage of providers who:	%	n
Read material on FGC in last 5 years	25	727
Discussed FGC with clients	43	727
Difficulty discussing FGC with clients	52	313
Discussed FGC with community	39	727
Difficulty discussing FGC with community	59	283
Enough info on physical effects of FGC	33	525
Willing to talk against FGC in public	86	727
Ever attended training on FGC	39	727

The role of health service providers in promoting its total abandonment should be further explored. Some community leaders expressed the view that provider should set a good example by first refusing to cut girls:

> --*It will discontinue if the medics refuse and stop circumcising. But if the medics will not stop, it will not cease.* (Clan elder, Kisii)

> -- *If the medical people advise against it all the time to those parents taking their daughters there, then I think the culture will die.* (Catholic priest, Nyamira)

However, some respondents felt that even if health providers did stop, FGC would revert to traditional circumcisers:

> --*We maintain the tradition of Abagusii….if the medics cannot do it, then the old "mamas" in the village will take over again.* (Nurse aide, Nyamira)

> --*Many people will go back home and start looking for traditional circumcisers to do it because it's their culture. Even if medics refused this thing, it will not vanish as I see.* (Young married women with girl child, Kisii)

Despite their willingness to participate in advocacy efforts, only 39 percent of providers had ever attended any training on FGC:

--With the necessary training and information on FGC and laws, more professionals who are against the practice would be willing to participate and contribute time and skills to this worthy cause. (MOH, Kisii)

--Of course! Why not! When you explain and tell them what happens during circumcision and the future of the girl, they will listen. You know the community is just ignorant about circumcision. That is why they keep sticking to this old tradition. (Clinical officer, Kisii)

--They would listen. More so, in my community, where I come from, even the surrounding community. They know I work with the Ministry of Health and if I go there, they can listen to me, they respect me and I can do it. They can take notice of what I'm telling them. (Midwife, Nyamira)

--It depends the way you approach the client. So with us, the medical or the paramedic staff, we are trained on how to approach our clients and communicate effectively. (Matron, Kisii)

Discussion and next steps

Clearly, FGC is considered an important cultural obligation among the Abagusii ethnic group. Women continue to be perceived as custodians of the practice, especially mothers-in-law and older relatives. Most believe they are acting in the girl's best interest by having them circumcised to enable the girl to marry and acquire status and respect. FGC is seen as a way to manage female sexuality and ensure modest and socially acceptable behavior. FGC among the Abagusii appears to have undergone numerous changes over the last 10 years in terms of its organization within the culture and the age, timing, procedures, and type of cut undertaken. In particular, the type of cut practiced appears to have changed significantly to become largely symbolic, cutting less tissue and using a less painful procedure. Pricking or nicking of the clitoris is a new procedure, carried out mostly by health professionals. Health providers, mostly nurses and other paramedics, are increasingly performing FGC within public health facilities, in private clinics, and most commonly at the girls' homes or in the village. FGC has become a popular service for providers because it offers them potential for economic gain and is socially acceptable and in demand, because clients view medical cutting as safer and more hygienic. This move towards using medical practitioners and medical facilities and procedures (such as anaesthesia and infection prevention) are seen by the community as appropriate responses to increased awareness of the health complications of FGC. The recent criminalization of FGC appears to have driven the practice underground, although substantial proportions of the community (and many providers) are unaware of the laws and policies regarding FGC.

In conclusion, the findings from the study suggest that the following steps should be taken to counter trends towards a sustained traditional practice that has become increasingly medicalized:

- The role of health providers in perpetuating FGC in this community seems clear; thus their active participation in advocating against the practice would be essential to reduce their perceived support for its continuation.

- The Ministry of Health needs to strengthen its facility-level supervision mechanisms in these districts to stop its staff from performing the practice. The MOH should develop guidelines for district supervisors on the appropriate actions to take to detect and deter the practice.

- Education on existing policies and laws is needed so that providers and other community leaders understand and can discuss FGC issues competently, dissuade communities from continuation, support women and girls who oppose FGC, and manage complications arising from FGC.

- Punitive measures should be taken against those caught practicing FGC. Local administration personnel (such as police, chiefs, Children's Officers, and social workers) should actively pursue those known to be involved and to close unregistered facilities and seasonal clinics.

- Community-wide approaches are needed that present FGC holistically, not just as a health issue but also as a practice that subjugates women and violates their rights to bodily integrity. Such a comprehensive approach should include all stakeholders, political, religious, cultural leadership, and involve women and girls as well as men and boys to encompass the entire community. The involvement of men is particularly important, as its is their overall dominance in society that has led to women supporting FGC as a means of gaining social identity and access to resources.

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